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In The

Supreme Court of the United States

October Term, 1996

HEALTHPARTNERS OF SOUTHERN ARIZONA d/b/a PARTNERS HEALTH PLAN OF ARIZONA, INC.,

Petitioner,

vs.

JOY ATKINS,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. In the relationship between ERISA removal and COBRA conversion, is an enrollee of a converted COBRA plan who terminates her converted plan prior to filing suit still a "participant" of an ERISA plan for purposes of removal, in light of this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)?

2. Is appellate review of an order of remand appropriate when collateral findings of substantive issues of law and of fact have been adjudicated by the lower court in its order of remand?

PARTIES TO THE PROCEEDING

Joy Atkins, a single person, Respondent.

RULE 29.6 LISTING

Pursuant to Rule 29.6 Petitioner Healthpartners of Southern Arizona, d/b/a Partners Health Plan of Arizona, Inc., is a private corporation licensed in the State of Arizona with no parents or subsidiaries.

Co-defendant Carol Marquez, M.D. was not a party to the Ninth Circuit appeal giving rise to this Petition.

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APPENDIX

Appendix A — Order of the United States District Court for the District of Arizona Filed December 5, 1996 ..... 1a

Appendix B — Order of the United States Court of Appeals for the Ninth Circuit Filed March 27, 1997 ..... 13a

Petitioner, Healthpartners of Southern Arizona, d/b/a Partners Health Plan of Arizona, Inc., respectfully petitions for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The findings of fact and conclusions of law of the United States District Court for the District of Arizona, remanding this action back to state court, are unreported and are reprinted in Appendix A. The United States Court of Appeals for the Ninth Circuit's unpublished Order of March 27, 1997, dismissing the appeal and denying the petition for writ of mandamus, is reprinted in Appendix B.

STATEMENT OF JURISDICTION

The Ninth Circuit order was issued on March 27, 1997. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This Petition primarily asks the Court to clarify and apply the relationship between ERISA and COBRA, to wit: In the relationship between ERISA removal (29 U.S.C. §§ 1132 and 1144) and COBRA conversion, (29 U.S.C. §§ 1161, *et seq.*), is an enrollee of a converted COBRA plan who terminates her converted plan prior to filing suit still a "participant" (29 U.S.C. § 1002(7)) of an ERISA plan for purposes of removal?

Statutory provisions involved are:

29 U.S.C. § 1002(7) provides as follows:

> The term "participant" means any employee

> or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1132(a)(1)(B) provides as follows:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought —
>
> (1) by a participant or beneficiary —
>
> * * *
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1144(a) provides as follows:

> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and

not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

28 U.S.C. § 1441(b) provides as follows:

Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

29 U.S.C. § 1161 provides as follows:

Plans must provide continuation coverage to certain individuals.

(a) In General

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

29 U.S.C. § 1162 provides as follows:

> Continuation coverage.
>
> For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:
>
> (1) Type of benefit coverage. — The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

29 U.S.C. § 1167 provides as follows:

> Definitions and special rules
>
> For purposes of this part —
>
> (1) Group health plan. — The Term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of Title 26) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. . . .

(2) Covered employee. — The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for one or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of Title 26).

(3) Qualified beneficiary. —

(A) In general. — The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan —

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee.

STATEMENT OF THE CASE

A. Introduction

This action examines the scope of federal court removal jurisdiction over state court actions brought by a participant in an employee benefit plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, *et seq.* ("ERISA") when the participant has continued the plan by COBRA continuation after terminating her employment.

B. Factual Summary

Petitioner Healthpartners of Southern Arizona, d/b/a Partners Health Plan of Arizona, Inc. ("Partners"), is a health maintenance organization ("HMO"). Pursuant to its contracts with employers, Partners administers and arranges for health care services for employees pursuant to employee benefit plans established under ERISA. Respondent, Joy Atkins, is a former employee of an employer which contracted with Partners for a health benefits plan for its employees. After she left her employment, Respondent chose to continue her coverage with Partners under the plan's COBRA conversion provision. Prior to filing suit against Partners, she terminated her health coverage with Partners.

Prior to August 26, 1995, Respondent was employed by El Dorado Hospital and Medical Center ("El Dorado") in Tucson, Arizona. During her employment, she received health benefits through an employee benefit plan contracted between Partners and El Dorado, for which El Dorado paid part of the premiums. A portion of the premiums were also paid by the employees.

On or about August 26, 1995, Respondent terminated her employment with El Dorado and began employment with Professional Nursing Services ("PNS"). Instead of enrolling in the PNS employee health benefits plan, Respondent chose to continue her coverage with Partners under her former employer's plan COBRA conversion provision, paying her own premiums in full.

On October 25, 1995, while still covered under her former employer's conversion plan and receiving medical services arranged for by Partners, Respondent suffered a rupture of an intracranial aneurysm with subsequent brain damage. Respondent claims that authorization for a CT scan requested

by her physician was delayed by Partners, thereby allowing the aneurysm to rupture before a timely diagnosis could be made. She claims that the "coverage dispute relating to benefits denied [by Partners]" (*see* section "C" below) was the cause of the ruptured aneurysm.

Respondent apparently terminated her COBRA conversion plan coverage with Partners effective November 1, 1995, at which time she enrolled in an employee benefit plan with her new employer to be effective on November 1, 1995. Respondent filed suit on or about June 7, 1996.

C. District Court Proceedings

Respondent sued Partners in the Superior Court for Pima County, Arizona on or about June 7, 1996, approximately seven months after terminating her COBRA conversion plan with Partners. On or about June 11, 1996, a First Amended Complaint was filed to correct some clerical errors in the Complaint. Respondent's Amended Complaint stated four causes of action: (1) breach of contract (alleging that Partners withheld consent for a medically necessary diagnostic test, specifically a CT scan); (2) negligence; (3) negligence per se (alleging violation of an Arizona statute); and (4) bad faith.

On or about July 1, 1996, Partners timely removed the state court action to the United States District Court for the District of Arizona, on the grounds that all of Respondent's state law claims were preempted by ERISA, 29 U.S.C. §§ 1132(a)(1)(B) and 1144(a); at the same time, Partners filed its Answer to the Complaint in the United States District Court. On or about July 2, 1996, Partners filed its Amended Notice of Removal and its Answer to the First Amended Complaint in the United States District Court.

On or about July 19, 1996, Respondent filed her Objection to Removal and Motion for Remand in the United States District Court, arguing that the United States District Court did not have original jurisdiction of this "coverage dispute relating to benefits denied [by Partners]" because she was not a "participant" in an employee benefit plan as defined by ERISA, 29 U.S.C. § 1002(7). Respondent's argument continues: since she was not a participant, she had no standing to sue under ERISA; since she had no standing under ERISA, ERISA did not apply; since ERISA did not apply, this case cannot be removed. Thus, the heart of Respondent's argument was that, because she exercised COBRA rights, she was not subject to ERISA.

Partners filed its Response to Plaintiff's Motion for Remand on or about July 29, 1996, arguing that Respondent was indeed a plan "participant"; in fact, without the plan, Respondent would have no claim at all against Partners. Since Respondent was a former employee who had received benefits under the ERISA plan's conversion provision, the definition of "participant" was satisfied; the subsequent termination of her conversion plan before filing her lawsuit had no bearing on her status as a plan "participant" as defined by ERISA.

On December 5, 1996, the United States District Court issued its Order remanding the case back to the state court, issuing substantive findings of fact and conclusions of law, including, but not limited to, the following:

(1) Respondent was not a plan "participant" under her conversion plan because:

> [her] claim was filed long after she had left her employment at El Dorado and long after her employer had ceased contributing toward her Partners insurance premiums. This is

> persuasive evidence that the Plaintiff was not an ERISA "participant."

(App. A, p. 6a); thus rejecting this Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (App. A, pp. 6a-7a). For reasons which are not important to this petition, the District Court did not have before it nor did it consider the controlling precedents, in addition to *Firestone*.[1]

(2) Respondent did not have standing to sue under ERISA because as of the date she filed the lawsuit, she had terminated her conversion coverage under the plan (App. A, pp. 8a-11a).

(3) Since Respondent was suing for monetary "damages" instead of for "benefits," she did not have standing to sue under ERISA (App. A, p. 11a).

(4) As a matter of law, Respondent's "damages action" was "such a tenuous, remote, and peripheral consequence of her employment" that it did not relate to her former employer's ERISA plan (App. A, p. 12a).

D. Appeal to the Ninth Circuit

On December 27, 1996, Partners filed its Notice of Appeal of the District Court's decision to the Ninth Circuit Court of Appeals, on the grounds that the District Court's remand order established substantive findings of fact and conclusions of law.

Respondent filed her Motion to Dismiss Appeal on or about February 7, 1997, arguing that the District Court's remand order was not an appealable final judgment pursuant to *Executive*

1. *See* argument I(C) below. The law is clear that a conversion policy for health benefits obtained pursuant to an ERISA plan is still an ERISA plan.

Software North America, Inc. v. U.S. District Court, 24 F.3d 1545 (9th Cir. 1994).

Partners filed its Opposition to Motion to Dismiss And Petition for Writ of Mandamus, arguing that the remand order was appealable because the order reached substantive issues; alternatively, since the District Court erred as a matter of law, review by mandamus was appropriate.

The Ninth Circuit issued its one-paragraph Order on March 27, 1997, dismissing Partners' appeal for lack of jurisdiction and denying Partners' petition for writ of mandamus (App. B, p. 13a).

REASONS FOR GRANTING THE WRIT

This Petition presents important legal issues (the relationship between ERISA and COBRA conversion) which apply to almost 150,000,000 Americans, most of whom are covered under ERISA-governed employee benefit plans, either as employees or as former employees.[2] Given the broad application of these two statutes to millions of Americans and the importance of the health benefits protected by these statutes, this Court should clarify the proper relationship between COBRA and ERISA on the questions presented.

This Petition also gives this Court the opportunity to give guidance to millions of employees and plans as well as to correct a clear error of law by the two lower courts in blatant disregard

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2. In 1995, 59.1 million Americans were enrolled in HMO plans, and 90 million were covered under PPO plans. In 1996, the HMO coverage rose to 67.5 million (no data is yet available for PPO coverage in 1996). Of the 149.1 million 1995 HMO and PPO plan enrollees, the great majority were members of ERISA-governed employee benefit plans, either as employees or as former employees with COBRA conversion policies. American Association of Health Plans, Division of Statistics, Washington, D.C.

of federal law and of this Court's ruling in *Firestone*: (1) a former employee covered under conversion benefits pursuant to her former employer's ERISA-governed employee health benefit plan is still a plan "participant" as defined by section 1002(7); and (2) a "participant" in an ERISA-governed employee health benefit plan cannot obviate Congress' clear intent to completely preempt this area of law by simply terminating her health benefit coverage before filing suit against the ERISA plan for monetary damages, thus claiming lack of standing to sue under ERISA.

Resolution of these questions (and the underlying policy regarding removal and remand of ERISA cases) has a broad societal application, as an ever-increasing number of Americans is receiving health benefits through ERISA-governed employee benefit plans. As employees leave their employment or are terminated (especially in the current era of corporate "downsizing"), more and more Americans are using their former employers' COBRA conversion health policies for continuing health coverage.

Consequently, there is a compelling public policy reason for the Court to consider and resolve these issues so that the millions of working Americans and their employers can be assured fair and uniform treatment throughout the federal court system.

I.

IN THE RELATIONSHIP BETWEEN ERISA REMOVAL AND COBRA CONVERSION, AN ENROLLEE OF A CONVERTED COBRA PLAN WHO TERMINATES HER CONVERTED PLAN PRIOR TO FILING SUIT IS STILL A "PARTICIPANT" OF AN ERISA PLAN FOR PURPOSES OF REMOVAL.

A. Introduction — Public Policy

Certiorari should be granted to clarify and confirm that the correct interpretation of "participant" is the *Firestone* interpretation, which includes a former employee, such as Respondent, with a colorable claim that she will prevail in a suit for benefits. It is important to clarify this application because of the very large number of plan participants and former employees who are still plan participants under conversion policies.

B. The *Firestone* decision

This Court, in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), settled a dispute over who was a "participant" as defined by ERISA, 29 U.S.C. § 1002(7) with standing to sue an employee benefit plan for benefits denied. The Court held:

> In our view, the term "participant" is naturally read to mean either "employees in, or reasonably expected to be in, currently covered employment," [citation omitted], or **former employees who** "have . . . a reasonable expectation of returning to covered employment" or **who have "a colorable claim" to vested benefits** [citation

> omitted]. In order to establish that he or she "may become eligible" for benefits, a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future. [emphasis added.]

Id., 489 U.S. at 117-118.

In order to assure Congress' clear intent to apply ERISA uniformly throughout the states (and especially its intent to completely preempt claims under 29 U.S.C. § 1132(a)(1)(B)), this Court should take this opportunity to clarify its application of the term "participant" as defined by ERISA. This Court should rule, consistent with *Firestone*, that the reference to "former employee" in section 1002(7) includes all those former employees (whether or not they are still "enrollees" in the benefit plan when they file suit) who have colorable claims to vested benefits while they were enrolled in the plan (including those who were enrolled in COBRA plans). These former employees (including Respondent) are subject to ERISA and removal.

C. Conversion policies under COBRA are covered by ERISA

The law is clear in the Ninth Circuit as well as other circuits that a conversion policy for health benefits obtained pursuant to a former employer's ERISA plan is still an ERISA plan. *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839 (9th Cir. 1994); *Tingey v. Pixley-Richards West*, 953 F.2d 1124 (9th Cir. 1992); *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812 (9th Cir. 1992); *Howard v. Gleason Corp.*, 901 F.2d 1154 (2nd Cir. 1990); *Gonzales v. Garner Food Services, Inc.*, 89 F.3d 1523, 1524, n.3 (11th Cir.), *cert. denied*, __ U.S. __, __ S. Ct. __, 1997 WL 134367 (U.S., May 19, 1997) ("COBRA [29 U.S.C. §§ 1161, *et seq.* (1994)] amended ERISA to require each

employer to allow former employees to elect to continue coverage under the employer's group health insurance plan for up to 18 months following termination of employment.").

Indeed, ERISA itself provides for conversion policies in its COBRA provisions (*see Gonzales, supra*). Unfortunately, the courts in the instant case ruled that Respondent's conversion policy was not an ERISA plan simply because it was an "individual policy" rather than a group plan and because Respondent's employer no longer contributed toward the premiums. Their blatant disregard of ERISA, COBRA and existing law needs to be corrected by this Court.

D. Former employee claimants and ERISA

The circuits have created two categories of former employee claimants: (1) those who claim benefits from the period of time while they were covered under the plan; these claimants may sue under ERISA; and (2) those who were never enrolled in the plan or who have already received all of the benefits to which they were entitled under the plan; these claimants may not sue under ERISA. This Court must clarify these two classes of former employee claimants so that both plans and employers as well as claimants know their rights and responsibilities. It is very important to the orderly administration of plan benefits that this Court clarify and confirm the application of ERISA to the first category, above, including Respondent. As is argued below, in this case the lower courts confused the categories and misapplied them. This misapplication must be clarified for the benefit of all employers and participants alike.

When, as here, the former employee claimant is suing based upon benefits from when claimant was in the plan, it does not matter that claimant was in a COBRA plan when suit was filed.

Regarding the first category (claims while covered by the plan), the majority of the circuits (including the Ninth) which have reviewed this issue have relied upon *Firestone* to hold that former employees certainly have the right to sue an employee welfare benefit plan if **while covered under the plan**, they did not receive a benefit to which they were entitled, pursuant to 29 U.S.C. §§ 1132(a)(1)(B) and 1002(7).[3]

Regarding the second category (a former employee who was **never enrolled** in the plan **or** who had **already received all the benefits** to which he/she was entitled), these claimants do not have standing to sue under ERISA because there would be no remaining benefits to claim.[4]

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3. *Flanagan v. Inland Empire Elec. Workers Pension Plan & Trust*, 3 F.3d 1246 (9th Cir. 1993) ("terminated non-vested participants" had standing to sue for monetary damages and injunctive relief against ERISA plan); *Ruocco v. BEHR, Inc.*, 903 F.2d 1232 (9th Cir.), *cert. denied*, 498 U.S. 899 (1990) (former employees presented colorable claim to entitlement to surplus dividend even though they had already received vested benefits); *Drennan v. General Motors Corp.*, 977 F.2d 246 (6th Cir.), *cert. denied*, 508 U.S. 940 (1993) (class members were eligible for the plan at the time the asserted breach of fiduciary duty occurred and thus had standing to sue as participants under ERISA); *Willett v. Blue Cross and Blue Shield of Alabama*, 953 F.2d 1335 (11th Cir. 1992) (employees were plan participants even though the plan was suspended before the date on which benefits were to begin); *Vartanian v. Monsanto Co.*, 14 F.3d 697 (1st Cir. 1994) (plaintiff who would have been entitled to greater benefits but for breach was a participant with standing); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan*, 883 F.2d 345 (5th Cir. 1989) (same); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1221 (5th Cir.), *cert. denied*, 506 U.S. 820 (1992) ("employer should not be able through its own malfeasance to defeat the employee's standing"); *Panaras v. Liquid Carbonic Industries Corp.*, 74 F.3d 786 (7th Cir. 1996) (former employee had standing to sue employer as participant for ERISA severance plan benefits).

4. *Harris v. Provident Life and Acc. Ins. Co.*, 26 F.3d 930 (9th Cir. 1994) (Cont'd)

Respondent in this case was clearly in the first category of former employee claimants (those claiming benefits while they were covered under the plan). Thus, her case was subject to ERISA and should have been removed. However, the District Court and Ninth Circuit panel in the case at bar have ignored their own circuit's precedent (supported by the other circuits cited above) when applying the concept of whether a former

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(Cont'd)
(former employee had never been enrolled in benefit plan and thus had no standing to sue pursuant to the two-part test of *Firestone*); *Freeman v. Jacques Orthopaedic & Joint Implant Surgery Medical Group*, 721 F.2d 654 (9th Cir. 1993) (same); *Curtis v. Nevada Bonding Corp.*, 53 F.3d 1023 (9th Cir. 1995) (same); *Boren v. Southwestern Bell Telephone Co.*, 933 F.2d 891 (10th Cir. 1991) (same); *Nishimoto v. Federman-Bachrach & Assoc.*, 903 F.2d 709 (9th Cir. 1990) (former employee who settled ERISA claim during litigation no longer had standing); *Sallee v. Rexnord Corp.*, 985 F.2d 927 (7th Cir. 1993) (former employee who had voluntarily left employment knowing that severance benefits did not vest unless employee was terminated did not have standing); *Berger v. Edgewater Steel Co.*, 911 F.2d 911 (3rd Cir.), *cert. denied*, 499 U.S. 920 (1991) (retirees who had already received special payment lacked standing); *Kuntz v. Reese*, 785 F.2d 1410 (9th Cir.), *cert. denied*, 479 U.S. 916 (1986) (former employees whose vested benefits had been distributed in lump sum lacked standing); *Mitchell v. Mobil Oil Corp.*, 896 F.2d 463 (10th Cir.), *cert. denied*, 498 U.S. 898 (1990) (same); *Raymond v. Mobil Oil Corp.*, 983 F.2d 1528 (10th Cir.), *cert. denied*, 510 U.S. 822 (1993) (same); *Joseph v. New Orleans Elec. Pension & Retirement Plan*, 754 F.2d 628 (5th Cir.), *cert. denied*, 474 U.S. 1006 (1985) (same); *Yancy v. American Petrofina, Inc.*, 768 F.2d 707 (5th Cir. 1985) (per curiam) (same); *Winchester v. Pension Committee of Michael Reese Health Plan*, 942 F.2d 1190 (7th Cir. 1991) (same); *Teagardener v. Republic-Franklin Inc. Pension Plan*, 909 F.2d 947 (6th Cir.), *cert. denied*, 498 U.S. 1027 (1991) (former employees who had received vested benefits upon partial termination of the plan were no longer "participants" with standing to sue for residual benefits that subsequently vested); *Crawford v. Lamantia*, 34 F.3d 28 (1st Cir.), *cert. denied*, __ U.S. __, 115 S. Ct. 1393 (1995) (plaintiff who was a current employee at the time of filing suit, but was a former employee having collected all vested benefits due at time of filing of first amended complaint, lacked standing under first prong of *Firestone*).

employee "may be eligible" to receive vested benefits under ERISA if she is not still enrolled in the benefit plan at the time the lawsuit is filed. The courts in this case seem to have misunderstood this concept, either: (1) by interchanging the terms "enrollee" and "participant" (thus leading to the narrow improper interpretation that to be a "participant" Respondent had to be "enrolled" on the date suit was filed); or (2) by blatantly ignoring this Court's decision in *Firestone*, as the Ninth Circuit panel in this case did when it condoned the District Court's decision which cited but then discounted *Firestone*. This Court must clarify the misunderstanding so that employers, plans, employees and the courts know the correct rules.

The District Court's Order herein was clearly but improperly motivated by its distress at Congress' failure to provide the Respondent with the full range of remedies she would have under state law.[5] However, the law is crystal clear on this subject. A plaintiff who is a former employee at the time suit is filed is clearly entitled to sue under ERISA, if she meets one of the two requirements set forth by this Court in *Firestone* which Respondent does. Respondent was not suddenly stripped of her standing to sue under ERISA merely because of her "former employee" status when she filed suit. Therefore, ERISA applies and removal was proper.

In its refusal to review the lower court's decision, the Ninth Circuit has taken a stand directly in conflict with: the decision

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5. Indeed, the District Court echoed Respondent's counsel's complaint against the allegedly unfair treatment Congress has created for Respondent by stating in its Order that ERISA "has frequently had the opposite effect of depriving employees of rights they had under state law without providing a corresponding federal remedy" (App. A, p. 4a), and noting " 'the remarkable legerdemain that has turned a statue [sic] designed to protect employee pension rights into a law that strips them of most of the protection they previously enjoyed under state law. . .' " [citations omitted]. (App. A, p. 5a).

of this Court; its own decisions; the decisions of the other circuits; and section 1002(7) as enacted by Congress.

As the Ninth Circuit has departed so far from the accepted and usual course of judicial proceedings by sanctioning such departure by the lower court, this Court should exercise its supervisory power by granting certiorari pursuant to Rule 10(a).

E. Eligibility for vested benefits as of the time suit is filed

The District and Ninth Circuit courts in this case have gone beyond any logical interpretation of *Firestone*. They ignored their own circuit's law (which is supported by the majority of circuits) in applying to a former employee plaintiff the concept of eligibility for vested benefits at the time the lawsuit is filed. Since the lower courts are confused about the proper application, this Court should clarify it.

The correct application of law is as follows: the plaintiff's right to **commence** the suit under ERISA is decided on the day of filing; the right to **continue** the case under ERISA is decided later. Thus: **(1)** on the date suit is filed, the court determines if the plaintiff (Respondent in this case) meets either of the two *Firestone* tests for former employees (a reasonable expectation of returning to covered employment or a colorable claim to vested benefits). If plaintiff meets either test, then the suit properly starts under ERISA (including removal) in federal court. **(2)** At a later date, the court may reconsider whether plaintiff still meets either of the two *Firestone* tests. If plaintiff still meets either test, the case stays under ERISA in federal court. However, if during the pendency of the lawsuit, plaintiff fails to meet either *Firestone* test, then ERISA jurisdiction (including removal) may end. The federal court may then exercise its discretion to keep the case in federal court or remand any state law claims to state court.

An example of these rules is *Nishimoto v. Federman-Bachrach & Assoc.*, 903 F.2d 709 (9th Cir. 1990). In *Nishimoto*, plaintiff properly began her suit under ERISA because she was a former employee who was eligible to receive vested benefits at the time she filed suit. However, after the suit was started, plaintiff compromised her right to be in federal court because during the course of the litigation, the plaintiff accepted a lump sum payment of all her vested benefits from her employer. After the settlement, plaintiff no longer met either *Firestone* test — she would not return to covered employment and all her vested benefits had been paid by the settlement. The Ninth Circuit ruled that because plaintiff's settlement of the ERISA claim constituted a "receipt of all the benefits she was due under the plan . . . the ERISA claim might have become subject to dismissal at that point." *Id.* at 715.

However, *Nishimoto* continues that because the suit was properly started under ERISA, the federal court could exercise its discretion to keep the remaining state law claims in federal court. "Thus, Nishimoto's status at the time of filing was critical only as to whether the [federal] court was deprived of the power **to adjudicate the remaining pendent state claims**." *Crawford v. Lamantia*, 34 F.3d 28, 32 n.5 (1st Cir. 1994). (Emphasis added).

Another example of these rules is *Harris v. Provident Life and Acc. Ins. Co.*, 26 F.3d 930 (9th Cir. 1994) which was heavily relied upon by Respondent to argue that she had no standing to sue under ERISA (and thus avoided ERISA removal) because at the time she filed her Complaint against Petitioner, she had terminated her health benefit plan with Petitioner. *Harris*, however, makes no such ruling; Respondent misinterpreted and misquoted its holding.

In *Harris*, the court looked to the plaintiff's status as a former employee at the time he filed suit only because he had

never been enrolled in the employee benefit plan; obviously, he had never been a plan "participant." Therefore he had no standing **at any time** to sue under ERISA to recover benefits to which he was never entitled. The only reason the court was interested in his status at the time of filing suit was to determine whether he was an employee or a former employee, at which point this Court's two-part test for former employees, set forth in *Firestone*, would be applied to render him a plan "participant" or not under section 1002(7). Since Harris had argued that during his actual employment, he reasonably expected to become a participant, the court had to decide the issue: "Whether a person is a plan participant must be decided as of the time of the filing of the lawsuit." *Id.* at 933. Mr. Harris, at the time he filed suit, was a former employee who met **neither** of the two tests under *Firestone*.

The District Court in the instant case took the *Harris* court's quotation out of context when it ruled that Respondent was not a plan "participant" because at the time she filed her lawsuit she had no benefit plan with Petitioner. This ruling is clearly in error and in contravention of Ninth Circuit law, but the Ninth Circuit itself let it stand, thus creating bad law.

Properly, the lower court should have considered whether Respondent (plaintiff below) met either *Firestone* test on the day suit was filed. Since Respondent did meet the test, her suit was under ERISA (including removal).

Since the lower courts are obviously confused about how to apply the *Firestone* tests, this Court must clarify that application.

F. "Damages" versus "Benefits"

The District and Ninth Circuit courts in this case have

seriously confused the terms "damages" and "benefits" in the context of ERISA. This Court should clarify the point.

The mere fact that an artfully pleaded state law Complaint may contain language asking for "damages" has no bearing on the fact that it is really a claim under ERISA for health benefits (a CT scan), allegedly denied or withheld. Simply because Respondent has characterized her withheld benefits as "damages" in her Complaint does not miraculously turn them into state common law compensatory and punitive damages, which are not available under ERISA.

Both Respondent and the District Court have ignored the clear law of the Ninth Circuit and have purported to cite Ninth Circuit rulings they believe stand for their convoluted proposition that merely asking for "damages" in a complaint renders Respondent ineligible to sue under ERISA and therefore immune to ERISA removal. They are wrong; their arguments are merely semantic. The Ninth Circuit case law stands for no such proposition. The instant Ninth Circuit panel has refused to correct such a convoluted finding, resulting in Petitioner being treated differently from all other ERISA plans, in contravention of the clear intent of Congress.

Those Ninth Circuit (and other circuit) cases that discuss the issue of "damages" versus "benefits" under ERISA deal with claims for statutory damages for breach of fiduciary duties in failing to disclose information under ERISA (29 U.S.C. § 1024(b)), not with employee welfare benefits withheld or denied. Those claimants (like Respondent) who seek benefits are still under ERISA and subject to removal.

In *Kuntz v. Reese*, 785 F.2d 1410 (9th Cir. 1986), *cert. denied*, 479 U.S. 916 (1986), the court ruled that former employees were not plan "participants" as defined by ERISA

and that their "damages" claim was not a "plan benefit" within the meaning of ERISA. However, the court reached this conclusion only because, since the former employees had already received their "vested benefits" in a lump sum, they received all they were due and were not "eligible to receive a benefit" or likely to become so, as of the time they filed their lawsuit. "The Kuntz plaintiffs do not allege that their vested benefits were improperly computed, rather they allege breach of fiduciary duty or of a duty to disclose information about benefits, thus any recoverable damages would not be benefits from the plan." *Id.* at 1411. Since they were not "participants," they did not have standing to sue the plan administrator under ERISA.

However, *Kuntz* did not stand for the proposition that all plaintiffs who had received all their vested benefits would be denied standing. (*See Flanagan* and *Ruocco, supra.*) The breach of fiduciary duty claims of those who had accepted lump sum benefits were distinguished in another Ninth Circuit decision, *Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406 (9th Cir. 1988): although the plaintiffs had "received their actuarily vested plan benefits," a constructive trust in their favor "may be construed as a 'benefit of any type from an employee benefit plan.' " *Id.* at 1417-18. In that case, the court found that plaintiffs were still plan "participants" with standing to sue under ERISA.

In *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan*, 883 F.2d 345 (5th Cir. 1989), the court reasoned as follows:

> The distinction between "benefits" and "damages" is not clear. This is in part attributable to use of words with overlapping meaning to describe mutually exclusive categories. . . . Clearly, a plaintiff alleging

> that his benefits were wrongly computed has a claim for vested benefits. . . . On the other hand, a plaintiff who seeks the recovery for the trust of an unascertainable amount, with no demonstration that the recovery will directly effect payment to him, would state a claim for damages, not benefits.

Id. at 349-350. In *Sommers*, the plaintiffs claimed that the amount received was not the full amount of vested benefits due; therefore, they were still eligible to receive the remaining amount of their vested benefits and had standing as plan "participants." In two other Fifth Circuit cases, however, the court ruled the plaintiff did not have standing because he had already received his vested benefits in full. *Yancy v. American Petrofina, Inc.*, 768 F.2d 707, 709 (5th Cir. 1985) and *Joseph v. New Orleans Electrical Pension & Retirement Plan*, 754 F.2d 628, 630 (5th Cir. 1985) (whose claims were held to be for "damages" for an additional amount under a plan amendment that was enacted after they had already received lump sum vested benefits pursuant to early retirement and were ineligible to receive future payments).

Finally, *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3rd Cir. 1993) stands for the proposition that a former employee can indeed sue an employee welfare benefit plan for "damages" under ERISA, 29 U.S.C. § 1132(a)(3)(B) in a direct action for breach of fiduciary duty.

In the case at bar, Respondent's claim is clearly not one for "damages" (even under ERISA), even though she uses that word in her complaint, but rather to recover a benefit denied under her health plan, **which she has already acknowledged** (*see* Statement of the Case, "B" and "C" above). She is clearly a plan "participant" under section 1002(7) and is suing "to recover

benefits . . . under the terms of the plan" pursuant to section 1132(a)(1)(B). Thus, she has standing to sue under ERISA, and her state law claims are completely preempted by ERISA; therefore, removal was proper.

This Court should grant certiorari to correct the egregious errors of law by the District Court and the Ninth Circuit in blatantly disregarding this Court's binding precedent in *Firestone*.

II.

APPELLATE REVIEW OF AN ORDER OF REMAND IS APPROPRIATE WHEN COLLATERAL FINDINGS OF SUBSTANTIVE ISSUES OF LAW AND OF FACT HAVE BEEN ADJUDICATED BY THE LOWER COURT IN ITS ORDER OF REMAND.

Unless this Court reverses the Ninth Circuit's decision dismissing the appeal and denying the petition for writ of mandamus, the purpose of ERISA will be clearly frustrated; the scope of ERISA applicability will be improperly narrowed in direct conflict with the clear purpose of ERISA as interpreted by this Court in *Firestone*.

Ordinarily, remand orders based on a lack of subject matter jurisdiction as identified in 28 U.S.C. § 1447(c) are not reviewable by appeal or otherwise. 28 U.S.C. § 1447(d); *Executive Software North America Inc., supra*, 24 F.3d at 1549. However, a remand order may be reviewed on appeal as a final collateral order if the order resolves the merits of a matter of substantive law apart from jurisdictional decisions. *Pelleport Investors, Inc. v. Budco Quality Theaters, Inc.*, 741 F.2d 273, 276-78 (9th Cir. 1984); *Harris v. Blue Cross and Blue Shield of Alabama, Inc.*, 951 F.2d 325, 327 (11th Cir. 1992). If the grounds

for the remand fall outside the scope of § 1447(c), the remand order is reviewable pursuant to a writ of mandamus. *Price v. PSA, Inc.*, 829 F.2d 871, 874 (9th Cir. 1987), *cert. denied*, 486 U.S. 1006 (1988); *see also Schmitt v. Insurance Co. of N. Am.*, 845 F.2d 1546 (9th Cir. 1988); and *In Re Glass Workers, Local No. 173*, 983 F.2d 725, 727 (6th Cir. 1993).

As a practical matter, the line between mandamus and appeal can often be subtle. *Clorox Co. v. U.S. District Court*, 779 F.2d 517 (9th Cir. 1985). The court has discretion to treat an appeal as a petition for writ of mandamus (or vice versa) when appropriate. *Lee v. City of Beaumont*, 12 F.3d 933, 936 (9th Cir. 1993).

Mandamus and/or appeal are appropriate in this case because the District Court's remand order was not based solely on a conclusion that the court lacked subject matter jurisdiction. Rather, the District Court made collateral substantive findings that: (1) Respondent was not a plan "participant" at the time she filed suit, and (2) Respondent's claim was not one for "benefits" due under a plan but for "monetary damages."

A recent decision by this Court holds that there exists a class of collateral orders which do not meet the definition of finality, but which are nevertheless immediately appealable under 28 U.S.C. § 1291 because they conclusively determine a disputed question that is separate from the merits and effectively unreviewable on appeal from a final judgment but too important to be denied review. *Quackenbush v. Allstate Insurance Co.*, __ U.S. __, 116 S. Ct. 1712 (1996). In *Quackenbush*, this Court abrogated its decision in *Thermtron Products, Inc. v. Hermansdorfer*, 423 U.S. 336 (1976), that "an order remanding a removed action does not represent a final judgment reviewable by appeal." *Id.* at 352-353.

The Ninth Circuit (as well as others) has held that **remand orders, including those based on jurisdictional decisions, are reviewable by mandamus.** *Lee, supra*, 12 F.3d at 936; *McDermott v. Lloyds Underwriters*, 944 F.2d 1199 (5th Cir. 1991). The Ninth Circuit panel in this case, however, has refused to follow its own circuit's precedent and has abused its discretion in denying the petition for a writ of mandamus when Petitioner has clearly met each and every one of the five guidelines for mandamus (discussed below), leaving Petitioner with no other remedy to pursue.

The guidelines for determining whether mandamus is proper are as follows: **(1)** the party seeking the writ has no other adequate means, such as direct appeal, to attain the relief desired; **(2)** the petitioner will be damaged or prejudiced in a way not correctable on appeal; **(3)** the district court's order is clearly erroneous as a matter of law; **(4)** the district court's order is an oft-repeated error or manifests a persistent disregard of federal rules; or **(5)** the district court's order raises new and important problems, or issues of law of first impression. *Executive Software North America, Inc., supra*, 24 F.3d at 1550-51, *citing United States v. Harper*, 729 F.2d 1216, 1221-22 (9th Cir. 1984). Not all five factors need to be satisfied; and the third factor [the existence of clear error as a matter of law] is dispositive. *Survival Systems of the Whittaker Corp. v. U.S. District Court*, 825 F.2d 1416 (9th Cir. 1987), *cert. denied*, 484 U.S. 1042 (1988).

As discussed below, each of the elements necessary for mandamus is present in this case; therefore, the Ninth Circuit's order denying Petitioner's request for review by mandamus was in error and should be reversed. Regarding the **first element**, since Partners's appeal was dismissed by the Ninth Circuit, Partners has **no other means** to review the lower court's remand order. Regarding the **second element**, the remand order clearly

creates **prejudice** against Partners which cannot be corrected on appeal, by depriving Partners of the procedures and processes of the federal forum and the expertise of the federal courts in applying the federal law of ERISA; also, Partners will be severely prejudiced if required to wait until the conclusion of state court litigation to appeal the remand order. Regarding the **fourth element**, the District Court's error in this clearly ERISA-governed case is **often repeated** because of the uncertainty of ERISA preemption/removal law; since the number of ERISA cases is growing, more opportunities for erroneous rulings will be created. Regarding the **fifth element**, the **"new and important problem"** raised by the District Court in its Order is, incredibly, its finding that because Respondent had terminated her conversion policy prior to filing suit, and apparently simply because she was a former employee, she was no longer reachable by ERISA. The District Court's order creates a new and important problem because it is a finding in direct conflict with every other federal decision involving former employees this Petitioner was able to locate and blatantly disregards this Court's two-prong test for former employees in *Firestone*. The District Court creates a new problem by giving a brand new meaning to the term "former employee," as discussed herein.

Finally, as to the most important **third element**, the District Court's order was **clearly erroneous as a matter of law**. "A question of law is 'clearly erroneous' for the purposes of a mandamus petition if we are 'left with the definite and firm conviction that a mistake has been committed.' [citation omitted] (*quoting United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948))." *United States v. Harper, supra*, 729 F.2d at 1222.

This case more than justifies a definite and firm conviction that a mistake was made, requiring review of the remand order. If this District Court's erroneous interpretation of the term

"participant" were valid, every former employee no longer covered by his/her employer's health benefits plan would be beyond the reach of ERISA. In fact, according to this District Court, every currently published case involving former employees would have to hold that they had no standing to sue under ERISA because the cases were filed after the former employees' plan coverage had terminated (which of course these cases did not so rule).

The error of this District Court has been recognized and condemned by other courts. "[A]n overly technical and narrow reading of the Supreme Court's reference to 'vested benefits' [in *Firestone*] would lead to the result that 'no former employee could bring an ERISA claim for welfare benefits allegedly accrued during employment.' " *Panaras v. Liquid Carbonic Industries Corp.*, 74 F.3d 786, 791 (7th Cir. 1996), *citing Andre v. Salem Technical Servs.*, 797 F. Supp. 1416, 1422 (N.D. Ill. 1992). This Court has stated, in granting standing to former employees, that "[i]n order to establish that he or she 'may become eligible' for benefits, a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits. . . ." *Firestone*, 489 U.S. at 117-118. "This language suggests not the narrow, technical reading of the phrase 'vested benefits' adopted by the district court, but a more expansive interpretation." *Panaras, supra*, 74 F.3d at 791.

As the Seventh Circuit corrected the district court's error in *Panaras*, so should the Ninth Circuit have done in the instant case; this Court should do so now.

CONCLUSION

For all of the foregoing reasons, Petitioner respectfully requests that its petition for a writ of certiorari be granted.

Respectfully submitted,

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APPENDIX A — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA FILED DECEMBER 5, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

No. CIV 96-443-TUC-FRZ

JOY D. ATKINS, a single person,

Plaintiff,

vs.

HEALTHPARTNERS OF SOUTHERN ARIZONA, dba PARTNERS HEALTH PLAN OF ARIZONA, INC.,

Defendant.

ORDER

I. INTRODUCTION

Plaintiff Joy D. Atkins was an employee of El Dorado Hospital and Medical Center in Tucson. During her employment there, Plaintiff received health insurance through Defendant. Partners Health Plan of Arizona ("Partners"). This HMO plan was made available to the employees of El Dorado, which paid a portion of the insurance premiums for its employees as a benefit.

On or about August 25, 1995, Plaintiff terminated her employment with El Dorado and went to work for Professional Nursing Services (PNS). PNS offered its employees health

coverage under a different HMO plan, CIGNA. However, Ms. Atkins did not immediately switch from Partners to CIGNA, but chose to extend her coverage under Partners and to assume the burden of the whole monthly premium herself. El Dorado ceased to pay any part of Ms. Atkin's insurance premiums.

Plaintiff began experiencing severe headaches which failed to respond to the medication prescribed by her primary care giver. On October 18, 1995, her physician faxed to Partners a "Specialist Referral" form requesting approval tor radiological diagnostic services in the form of a CT scan. The physician indicated possible hypoglycemia as the basis of the request. On October 20, 1995, the physician changed the basis to "severe headaches — not responsive to meds." Plaintiff's Exhibit A. On October 25, 1995, Plaintiff suffered an intracranial rupture of an aneurysm.

In June of 1996, Plaintiff brought suit in the Arizona Superior Court asserting that Partners' withholding of approval of the CT scan was a breach of contract and the proximate cause of her injury.[1] She further alleged claims of negligence,

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1. The Plan included coverage for "All Medically Necessary diagnostic and therapeutic radiology services and laboratory tests provided on an outpatient basis by Participating Providers, when provided or arranged by a Primary Care Physicians" "Medically Necessary" is defined in the Plan as "[T]hose services required to identify or treat an illness that is either diagnosed or reasonably suspected. To be Medically Necessary, a service must a. be required to treat an illness or injury; and b. be consistent with the diagnosis and treatment of the Member's conditions; and c. be in accordance with the standards of good medical practice; and d. be performed at the most appropriate level of care for the Member as determined by the Member's medical condition and not the member's financial or family situations, or the distance the Member lives from the hospital or any other nonmedical factor; and e. not be for the convenience of the Member, nor the Member's family or the Member's physician or another health care provider."

negligence per se, and bad faith. On July 1, 1996, Defendant removed the case to federal court under 28 U.S.C. § 1446, asserting that all the claims brought by Plaintiff are governed by § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), and thus involve a federal question over which this Court has original jurisdiction. Plaintiff opposes the removal and requests remand to the state court, arguing that because she lacks standing to bring a claim under ERISA, this Court lacks jurisdiction.

II. JURISDICTION

The party seeking removal has the burden of establishing federal jurisdiction. *Westinghouse Electric Corp. v. Newman & Holtzinger,* 992 F.2d 932, 934 (9th Cir. 1993); *Emrich v. Touche Ross & Co.,* 846 F.2d 1190, 1195 (9th Cir. 1988) *citing Wilson v. Republic Iron & Steel Co.,* 257 U.S. 92, 97 42 S. Ct. 35, 37, 66 L.Ed. 144 (1921), and the removal statute is strictly construed against removal jurisdiction. *Id. citing Libhart v. Santa Monica Dairy Co.,* 592 F.2d 1063, 1064 (9th Cir. 1979)

The general rule is that only state court actions that originally could have been filed in federal court may be removed by the defendant and that absent diversity of citizenship, federal question jurisdiction is required. *Caterpillar Inc. v. Williams,* 482 U.S. 386, 392, 107 S.Ct. 2425, 2429, 96 L.Ed.2d 318 (1987). The presence or absence of federal question jurisdiction is governed by the "well-pleaded complaint" rule which provides that federal jurisdiction only exists when a federal question is presented on the face of the Plaintiff's properly pleaded complaint. *Id.; Westinghouse* at 934, *citing Salveson v. Western States Bankcard Ass'n,* 731 F.2d 1423, 1426 (9th Cir. 1984).

One exception to the general "well-pleaded complaint" rule

is the doctrine of "complete preemption." *Stikes v. Chevron USA. Inc.*, 914 F.2d 1265, 1267 (9th Cir. 1990), *cert. denied* 500 U.S. 917, 111 S.Ct. 2015, 114 L.Ed.2d 101 (1991). This corollary has been applied to ERISA; the doctrine does not, however, always justify removal. *Westinghouse*, 992 F.2d at 935 *referring to Caterpillar*, 482 U.S. at 390, 107 S.Ct. at 2428. Furthermore, "a case may not be removed to federal court on the basis of a federal defense, including the defense of pre-emption, even if the defense is anticipated in the plaintiffs complaint and even if both parties concede that the federal defense is the only question truly at issue." *Caterpillar*, 482 U.S. at 393, 107 S.Ct. at 2430.

III. ERISA

Congress enacted ERISA in 1974 to protect the right of participants in private pension plans to a stable and secure source of retirement income, but that statute has frequently had the opposite effect of depriving employees of rights they had under state law without providing a corresponding federal remedy. *Olson v. General Dynamics Corp.*, 960 F.2d 1418, 1423 (9th Cir. 1991) (concurring opinion of Judge Reinhardt). The federal courts have routinely found state tort and implied contract remedies preempted by § 514(a) even when ERISA provides no substitute for the state cause of action. *Id.* at 1424.

Section 514(a) of ERISA provides that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Section 514(c)(1) indicates the preemption provision extends to all state common law causes of action which relate to benefit plans. The Supreme Court has described this clause as "deliberately expansive." *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, L.Ed.2d 39 (1987).

Appendix A

The Ninth Circuit has noted that "the great majority of cases in which this Court and the Supreme Court have held that ERiSA preempts state common law claims have involved situations where the plaintiff alleged that plan administrators were not providing benefits in accordance with the terms of the plan." *Olson*, 960 F.2d at 1422. The Circuit has also written: "Notwithstanding the remarkable legerdemain that has turned a statue designed to protect employee pension rights into a law that strips them of most of the protection they previously enjoyed under state law, there are limits to the unusually broad preemptive sweep we have afforded ERISA . . . [T]he Act does not preempt the state-law claims of plaintiffs who are without standing to challenge ERISA violations." *Concha v. London*, 62 F.3d 1493 (9th Cir. 1995).

Defendant states that Plaintiff has asserted a claim for improperly withheld benefits under an ERISA plan, and thus is subject to the Act. Defendant's Response to Motion for Remand at 2. Plaintiff's reply is that Ms. Atkins ceased to be subject to ERISA, which covers employer-plans, once she was no longer an employee of El Dorado. Defendant's Objection to Removal and Motion for Remand at 7, 8. As a non-participant, Plaintiff asserts, she lacks standing to bring any claim under ERISA and this Court lacks the subject matter jurisdiction to hear such a claim.

A. PARTICIPANTS UNDER ERISA

ERISA carefully enumerates the parties entitled to seek relief under its enforcement provisions; only participants, beneficiaries, fiduciaries, or the Secretary of Labor may bring a claim in federal court. *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 27, 103 S.Ct. 2841, 2855,

77 L.Ed.2d 420 (1983); *Cripps v. Life Ins. Co. of North America*, 980 F.9d 1261, 1265 (9th Cir. 1992).

Defendant claims that Ms. Atkins qualifies as a "participant" under the Act. In ERISA's terms, a "participant" is defined as:

> "[A]ny employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any benefit."

29 U.S.C. § 1002(7). The Ninth Circuit has held that whether a person is a plan participant is to be determined as of the time of the filing of the lawsuit. *Harris v. Provident Life and Acc. Ins. Co.*, 26 F.3d 930 (9th Cir. 1994) *citing Olson* at 1422. In the instant case, Ms. Atkins' claim was filed long after she had left her employment at El Dorado and long after her employer had ceased contributing payments toward her Partners insurance premiums. This is persuasive evidence that the Plaintiff was not an ERISA "participant."

B. RETURN TO EMPLOYMENT AND VESTED INTERESTS

Defendant argues that Plaintiff is, nevertheless, a "participant" because the Supreme Court has read the definition of "participant" to include former employees who have a reasonable expectation of returning to covered employment or

have a colorable claim to vested benefits. *Firestone Tire and Rubber Co. v. Burch,* 489 U.S. 101, 117, 109 S.Ct. 948, 958, 103 L.Ed.2d 80 (1989) *quoting Kuntz v. Reese,* 785 F.2d 1410, 1411 (9th Cir. 1986) (per curiam), *cert. denied,* 479 U.S. 916, 107 S.Ct. 318, 93 L.Ed. 2d 291 (1986). Conversely, the Supreme Court noted that "[A] former employee who has neither a reasonable expectation of returning to covered employment nor a colorable claim to vested benefits, however, simply does not fit within the phrase 'may become eligible." *Id. quoting Saladino v. I.L.G.W.U. National Retirement Fund,* 754 F.2d 473, 476 (2d Cir. 1985). Accordingly. Defendant bears the burden of demonstrating that Ms. Atkins was a "participant" under the reading of the term in *Firestone.*

Defendant does not argue that Ms. Atkins planned or plans to return to work at El Dorado. Instead, Defendant argues that Ms. Atkins obtained her HMO membership through her employment at El Dorado, and that her claim is nothing more than a coverage dispute for "vested" benefits which she sought pursuant to an ERISA plan. "Thus, the undeniable truth of the matter is that she made a claim for a benefit under an ERISA plan while she was a member and while she was entitled to receive medical benefits from that HMO plan." Defendant's Response to Plaintiffs Motion for Remand at 4.

Defendant further argues: "In this case, the plaintiff doesn't just have a 'colorable claim,' she has an actual claim to a benefit under the insurance coverage which was originally provided to her through her employment at El Dorado Medical Center. The mere fact that she subsequently left that employment or that she decided to terminate her insurance coverage before filing her complaint in the Pima County Superior Court has no bearing upon her status as a plan 'participant' . . . Nothing which Plaintiff

has cited to this Court should leave (sic) this Court to conclude that Plaintiff's decision to keep her HMO coverage after leaving El Dorado Medical Center somehow 'transformed' this plan from an ERISA to a non-ERISA plan." *Id.* at 5.

It is not entirely clear whether Defendant argues that the vested benefit Plaintiff enjoyed was the initial acquisition of the HMO plan through El Dorado Hospital or the option to keep the HMO plan following her employment. Neither characterization is supported by ERISA's legislative history or by existing Ninth Circuit case law. At the time the original Act was passed. Congress described the concept of "vesting" thus:

> "One of the major private pension plan considerations centers around the concept of vesting. Vesting refers to the nonforfeitable right of interest which an employee participant acquires in the pension fund. The benefit credits may vest in the employee immediately, although in most cases participants do not become eligible for vesting of benefits until a stipulated age or period of service or a combination of both. is attained. Upon compliance with the basic requirements of age or service, many plans will grant their participants vested rights to those benefits earned to that time. However, should employment terminate prior to such time, the employee will receive no benefits."

H.R.Rep. No. 533, 93d Cong., 2d Sess., *reprinted in* 1974 U.S.Code Cong. & Admin.News 4639, 4644-45. Defendant, who bears the burden of establishing federal jurisdiction, has cited

no persuasive authority in support of his argument that an ERISA health insurance plan initially obtained through an employer but subsequently preserved by a departing employee entirely at her own cost and in her own name, is a "vested benefit" of the past employment.[2]

ERISA was principally created to protect the rights held by current employees with benefits and retirees whose benefits in the forms of pensions and insurance policies have vested.[3] Thus, the Act focuses on existing relationships between an employee and an employer,[4] be that through a pension plan the employee

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2. Defendant's argued definition may be compared to examples of what case law has held a vested benefit to be. For example, in *Mitchell v. Mobil Oil Corp.*, 896 F.2d at 474, the Plaintiff had received all of his vested pension benefits in a lump sum, and so had received the full extent of his benefits and was no longer eligible to receive future payments. In *Olson v. General Dynamics*, the court wrote "At the time he filed this suit, Olson was receiving benefits from all three companies. Olson was therefore a 'participant' in each company's employee benefit plan . . ." *Id.* at 1422. These treatments of the term "vested" do not tend to support Defendant's definition.

3. S.Rep. No. 127, 93d Cong., 2d Sess., *reprinted in* 1974 U.S.Code Cong. & Admin. News 4639. H.R.Rep. No. 533, 93d Cong., 2d Sess., *reprinted in* 1974 U.S.Code Cong. & Admin. News 4639. "The primary purpose of the bill is the protection of individual pension rights, but the committee is constrained to recognize the voluntary nature of private retirement plans." House Report at 4639.

4. Congress was particularly concerned with the perceived inequitable treatment of employees who had relied on their employers' guarantees of certain benefits. "In almost every instance, participants lose their benefits not because of some violation of federal law, but rather because of the manner in which the plan is executed with respect to its contractual requirements of vesting or funding . . . Thus, under present law, accumulated pension credits

(Cont'd)

receives on retirement or an insurance premium that is paid for him during employment; whether or not the employee is actively working for the employer is not especially relevant. See *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 245 (5th Cir. 1990) (preemption exists where a claim affects the relationship among the traditional ERISA entities: the employer, the plan, and its fiduciaries and the participants and beneficiaries); *Hook v. Morrison Milling Co.*, 38 F.3d 776, 781 (5th Cir. 1994); *Weaver v. Employers Underwriters, Inc.*, 13 F.3d 172, 176-77 (5th Cir. 1994) (state-law claim by contractor did not affect relationship between traditional ERISA entities). ERISA was not created to regulate the relationship between an individual subscriber to a health plan outside of the employer-employee relationship.[5]

Ninth Circuit law holds that non-employees, without existing ties to a former employer's ERISA plan, lack standing to sue under ERISA. In *The Meadows v. Employers Health Insurance*, 47 F.3d 1006 (9th Cir. 1995), the Ninth Circuit held that federal jurisdiction did not exist "because neither the Meadows nor the Friedels had any existing ties to the ERISA plan in 1990. Mr. Friedel terminated his employment with School Services on December 29, 1989." *Id.* at 1009; *see also Harris v. Provident Life*, 26 F.3d 930 (9th Cir. 1994).

Plaintiff argues that she similarly lacked any tie to her

(Cont'd)
can be lost even when separated employees are within a few months, or even days, of qualifying for retirement. The proposed bill would, therefore, establish minimum standards of vesting, funding, and fiduciary and a system of compulsory benefit insurance to protect the security of pension rights." House Report at 4643.

5. Congressional Reports, *supra.*

former employer's ERISA plan. She argues that her right to have a CT scan performed existed due to her own payment of insurance premiums under an individual contract with Partners and the fact that she initially purchased that insurance through El Dorado was simply fortuitous. Objection to Removal and Motion for Remand at 7, 8, 10; Plaintiff's Reply to Defendant's Response at 2, 7. This severance of El Dorado's participation in Ms. Atkin's health insurance through Partners. in light of the legislative goals of ERISA and the Ninth Circuit's case law, persuades this Court that Plaintiff had no "vested interest" as contemplated by ERISA, and therefore her state-law claims do not relate to an ERISA plan.

C. CLAIMANT SEEKS DAMAGES

While Defendant casts Plaintiffs claim as one for vested benefits, Plaintiff emphasizes that she seeks damages. The Ninth Circuit has stated "[c]laimants who seek a damage award rather than vested benefits improperly withheld, lack standing to bring suit under ERISA." *Nunez v. Monterey Peninsula Engineering, et al.*, 867 F.Supp 895, 901 (N.D.Cal. 1994) *citing Mitchell*, 896 F.2d at 474. On the face of Plaintiffs complaint, there is no indication that she seeks a medical benefit wrongfully denied her. Instead, she asserts claims of negligence, breach of contract, and bad faith, and prays for judgment in an amount deemed just and reasonable by the court and for attorneys fees. Thus, under *Nunez*, Plaintiff lacks standing to bring her claim for damages under ERISA.

IV. CONCLUSION

The Ninth Circuit has observed that "[d]espite the breadth of ERISA's preemption provision, the Supreme Court has held

that not all state law claims are preempted." *The Meadows* at 1009 *citing Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 2836 (1988) and *quoting Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2899-9900, 77 L.Ed.2d 490 (1983) ("some state actions may effect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan"). In this case, Plaintiffs damages action brought against the health insurance plan which she opted to keep, entirely at her own expense, after ending her relationship with her employer, is such a tenuous, remote, and peripheral consequence of her employment, that the goals of ERISA are not furthered by ERISA preemption. Defendant has not discharged his burden of establishing federal jurisdiction with persuasive argument or authority.

Because Defendant has not demonstrated that federal question jurisdiction exists, the question of federal jurisdiction is governed by the well-pleaded complaint rule. Under that test, this Court finds that Plaintiff has not pleaded a federal claim. There being no ERISA, general federal question, or diversity basis for jurisdiction, it is hereby ORDERED that this case be REMANDED to the Superior Court of the State of Arizona, In and For the County of Pima.

DATED this 5th day of December, 1996.

s/ Frank R. Zapata
FRANK R. ZAPATA
United States District Judge

APPENDIX B — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT FILED MARCH 27, 1997

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

No. 97-15169

DC# CV 96-443-FRZ
Arizona (Tucson)

JOY D. ATKINS, a single person,

Plaintiff-Appellee,

vs.

HEALTHPARTNERS OF SOUTHERN ARIZONA, d/b/a PARTNERS HEALTH PLAN OF ARIZONA, INC.,

Defendant-Appellant.

ORDER

Before: SNEED, FARRIS and THOMAS, Circuit Judges

Appellee's motion to dismiss this appeal for lack of jurisdiction is granted. *See* 28 U.S.C. § 1447; *Executive Software v. U.S. District Court,* 24 F.3d 1545, 1549 (9th Cir. 1994).

Appellant's petition for writ of mandamus is denied.

A certified copy of this order sent to the district court shall constitute the mandate.

Appendix B

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A TRUE COPY
CATHY A. CATTERSON
Clerk of Court
ATTEST
MAR 27 1997

by: s/ illegible
Deputy Clerk

OPPOSITION

BRIEF

Supreme Court, U.S.
FILED
JUL 14 1997
CLERK

(2)

No. 96-2051

In The

Supreme Court of the United States

October Term, 1996

HEALTHPARTNERS OF SOUTHERN ARIZONA d/b/a PARTNERS HEALTH PLAN OF ARIZONA, INC.,

Petitioner,

vs.

JOY ATKINS,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

A BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does a former employee, who has no reasonable prospect of re-employment and no colorable claim to benefits under an ERISA or COBRA plan have standing to pursue a claim as a "participant" under the clear meaning of 29 U.S.C. § 1002(7) and as that statute has been appropriately interpreted by this Court in its decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 103 L.Ed. 2d 80, 109 S.Ct. 948 (1989)?

2. Under the clear language of 28 U.S.C. § 1447(d), is appellate review of a district court's order of remand appropriate where the sole basis of the order of remand is a lack of subject matter jurisdiction?

PARTIES TO THE PROCEEDING

The Petition accurately lists the parties to the proceeding, and the Rule 29.6 listing contained in the Petition is accurate.

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A BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent, Joy Atkins ("Atkins"), opposes Petitioner's, Healthpartners of Southern Arizona, d/b/a Partners Health Plan of Arizona, Inc. ("Partners") petition for a Writ of Certiorari to review the judgment of the United States Circuit Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

Partners has included the decision of the United States District Court for the District of Arizona and the unpublished Order from the Ninth Circuit Court of Appeals in its Appendix.

However, Partners has failed to mention that it has filed a Motion for Reconsideration under Rules 59 and 60 of the Federal Rules of Civil Procedure with the District Court and, as of the time of this writing, the District Court has not disposed of that Motion.

STATEMENT OF JURISDICTION

This Court, for reasons which will be discussed at more length *infra*, should not and cannot exercise jurisdiction to review this matter pursuant to 28 U.S.C. § 1254(1) in that said provision is superseded by the clear language of 28 U.S.C. § 1447(d) which prohibits appellate review in any form of remand orders based upon a district court's finding of lack of subject matter jurisdiction.

STATUTORY PROVISIONS INVOLVED

The relationship between ERISA removal (29 U.S.C. §§ 1132 and 1144) and COBRA (29 U.S.C. § 1161 *et seq.*) is of no consequence to this proceeding. For purposes of this proceeding, Atkins concedes that were she a participant in a converted plan at the time this litigation was initiated, ERISA removal would have been appropriate. Thus, Partners' reference to 29 U.S.C. § 1161 is surplusage and may be ignored.

Partners has clearly omitted two very relevant statutory provisions which relate to this Court's jurisdiction to review the District Court's Order of Remand.

28 U.S.C. § 1447(c) provides, as follows:

> A motion to remand the case on the basis of any defect in the removal procedure must be made within 30 days after the filing of the notice of removal under section 1446(a)[28 U.S.C. § 1446(a)]. If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded. An order remanding the case may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of the removal. A certified copy of the order of remand shall be mailed by the clerk to the clerk of the State court. The State court may thereupon proceed with such case.

28 U.S.C. 1447(d) provides, as follows:

> An order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise, except that an order remanding a case to the State court from which

it was removed pursuant to section 1443 of this title shall be reviewable by appeal or otherwise.

Otherwise, Partners recitation of statutory provisions is acceptable to Atkins.

STATEMENT OF THE CASE

A. Introduction

This action involves the question of whether a person who brings a claim for damages constitutes a "participant" under an employee benefit plan as defined by the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA") when that person is a former employee with no reasonable expectation of re-employment and no colorable claim to benefits under the plan at the time of bringing suit.

Also, this Court must examine whether it has jurisdiction to consider a petition for writ of certiorari where the district court's order of remand is based solely on its determination that it lacks subject matter jurisdiction to resolve the claim.

B. Factual Summary

Respondent, Joy D. Atkins ("Atkins") was at one time an employee of El Dorado Hospital and Medical Center in Tucson, Arizona. While employed there, Atkins was provided insurance as a benefit of her employment under a HMO plan offered by Petitioner (hereinafter "Partners") through her employer. El Dorado paid a portion of

Atkins' premium for this insurance while she was employed there.

On August 25, 1995, Atkins terminated her employment with El Dorado and went to work for another company. Atkins' new employer offered its employees health care coverage benefits under a different HMO plan, CIGNA. Upon her re-employment, Atkins did not immediately enroll in the CIGNA plan, because she was not immediately eligible for coverage under that plan. Instead, to avoid a gap in coverage, she continued her health insurance coverage for a short period of time under Partners as allowed and required by COBRA.

While still entitled to benefits under Partners' coverage, Atkins began experiencing severe headaches which did not respond to the medication prescribed by her primary care provider ("PCP"). On October 18, 1995, because of these unremitting headaches, Atkins' PCP faxed a "Specialist Referral" form to Partners requesting approval for radiological diagnostic services in the form of a CT scan. In this request, the PCP erroneously indicated "possible hypoglycemia" as the basis for the request. On October 20, 1995, realizing the error in her provisional diagnosis, the PCP changed the diagnosis to "severe headaches – not responsive to meds." On October 25, 1995, Atkins suffered an intra-cranial rupture of an aneurysm, which has rendered her completely and permanently disabled.

After the intra-cranial event, and substantially prior to filing suit in this case, Atkins dropped her coverage with Partners and, having achieved eligibility through

her new employer, obtained health insurance coverage through CIGNA.

The action giving rise to this proceeding was filed on Atkins' behalf in the Arizona Superior Court in June 1996 claiming damages for pain and suffering, emotional distress, loss of the enjoyment of life, lost earning capacity, and post-Partners'-coverage medical expenses.[1] The theories underlying that action were negligence, breach of contract, negligence *per se*, and bad faith. Nowhere under any conceivable reading of her pleadings has Atkins alleged that, **at the time of filing her suit**, she had a continued or colorable right to have a diagnostic CT scan performed, or that she was entitled to be reimbursed the cost of such a procedure (which she never paid) as a benefit under the Partners' plan. In other words, Atkins never claimed she had any colorable claim to benefits – arising either out of ERISA or COBRA – under Partners' plan at the time of filing her suit. Instead, her action has sounded and still sounds solely for damages. Additionally, Partners has never claimed – up until this Petition was filed – that Atkins remains or ever was entitled to the diagnostic CT scan or had any colorable claim to having it performed at the time Atkins filed suit.

Partners removed this action to the federal district court. Atkins objected to the removal and moved for

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[1] Atkins does not claim Partners failed to pay any medical expense which she actually incurred prior to termination of her coverage by Partners. All medical expenses claimed in her lawsuit relate to those incurred as a result of the ruptured aneurysm post termination of coverage.

remand. The district judge granted the remand and determined that the federal court did not have subject matter jurisdiction over the case. [Appendix A to Partner's Petition]

Partners then sought review in the Ninth Circuit Court of Appeals via both direct appeal and mandamus. The Ninth Circuit refused to review based on its holding in *Executive Software v. U.S. District Court*, 24 F.3d 1545, 1549 (9th Cir. 1994). [Appendix B to Partners' Petition]

Partners now petitions this Court for a Writ of Certiorari.

C. District Court Proceedings

While Atkins has sufficiently summarized the district court proceedings above, candor requires that comment be made on Partners' statement that "[T]he heart of [Atkins'] argument was that, because she exercised COBRA rights, she was not subject to ERISA." It is conceded that argument was made. It did not, nor does it, lie at the heart of Atkins' argument. Given the clear statutory definition [29 U.S.C. § 1002(7)] of who – for standing purposes – constitutes a participant under an ERISA plan, as has been succinctly and clearly interpreted by this Court in *Firestone Tire and Rubber Company v. Bruch*, 409 U.S. 101, 103 L.Ed. 2d 80, 109 S.Ct. 948 (1989), the "ERISA vs. COBRA issue" is a non-issue. Any suggestion by Partners that this Court should dwell on that question is nothing more than a diversionary tactic.

The sole issue – apart from the jurisdictional question – dispositive of Partners' Petition has to do with whether

or not Atkins had standing to bring an action as a "participant" under an ERISA plan at the time she filed suit in June 1996. Indeed, in her Objection to Removal and Motion for Remand, Atkins specifically averred that '[p]rior to the initiation of this litigation, Plaintiff terminated her coverage with Defendant and **was entitled to no benefits under Defendant's insurance policy** [emphasis added]." Until its bald assertion,[2] which is completely devoid of factual basis or authority, in this Court that Atkins had or made a colorable claim for benefits at the time this litigation was brought, Partners has never disputed that statement.

D. Appeal to the Ninth Circuit

Partners' statement of what occurred on appeal to the Ninth Circuit is a fair summary of those proceedings.

REASONS FOR DENYING THE WRIT

It is indisputable that millions of Americans are covered under policies of health insurance governed by ERISA. And, many of those millions convert their benefits under COBRA. However, whether or not a COBRA converted policy continues to be controlled by ERISA is

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[2] *See*, page 23 of Partners' Petition wherein it misrepresents:

> "In the case at bar, Respondent's claim is clearly not one for 'damages' . . . **which she has already acknowledged** . . . [emphasis in original]"

immaterial to the issues involved in this litigation. Irrespective of any involvement with COBRA, at the time the instant litigation was commenced, Atkins was a former employee of the employer through whom the Partners plan was obtained with no reasonable expectation of returning to covered employment and no colorable claim to benefits under the plan through either ERISA or COBRA. As such, she lacked standing to bring an action under ERISA.

Contrary to Partners' protestation that there is clear error arising out of the lower courts' decisions on the issue of standing, the decisions of those courts are on all fours with the unambiguous language set forth in 29 U.S.C. § 1002(7); the likewise pellucid reasoning of this tribunal in *Firestone, supra*; and each and every one of the decisions referred to in footnotes 3 and 4 of Partners' Petition.[3] It is not Atkins who distorts or expands any concepts discussed by the statute or any decisional interpretations through the ploy of "semantics". Rather, it is Partners who urges a gross and mutated definition of the term "participant" to suit its needs – not society's – in an attempt to create for Atkins a fabricated, unfounded standing under ERISA.

The argument that ERISA can be avoided by a former employee's "simply terminating her health benefit coverage" is akin to arguing that Atkins planned to have the

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[3] Partners, without any attempt at analysis *vis-a-vis* the question before this Court, refers to numerous cases which discuss the standing issue. None of these cases addresses the real issue before this Court in any meaningful fashion, nor does Partners develop such a meaningful relationship.

stroke giving rise to this action and which has permanently disabled her.[4] In the vast majority of instances, a decision to forego future health insurance coverage by one with a permanent major debilitating affliction in order to pursue litigation would be anything but the "simple" process Partners describes.

What Partners is asking this Court to do is to expand upon the "remarkable legerdemain that has turned a statute designed to protect employees' pension rights into a law that strips them of most of the protection they previously enjoyed under state law," *Concha v. London*, 62 F.3d 1493, 1505 (9th Cir. 1995), by rewriting the statute conferring standing and convoluting its own and the various circuit courts' decisional law on that issue. The only societal goal which would be advanced by granting the relief sought by Partners would be to cast in bronze the maxim that "the insurer [always] wins and the insureds lose." *Marshall v. Bankers Life and Casualty Company*, 2 Cal 4th 1045, 10 Cal. Rept. 2d 72, 832 P.2d 573, 585 (1992). To arrive at such a result, this Court would not have to clarify its and the circuits' earlier decisions, but would have to engage in verbal gymnastics and factual distortion. Verbal fantasy would need become legal reality. Society would not benefit. Partners would. It is, indeed, ironic that Partners would choose to use the words "fair . . . treatment" in the same sentence[5] as one of its goals in bringing this Petition. It seeks a resolution

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[4] The rupture of an intra-cranial aneurysm has similar results for the victim as those associated with a stroke.

[5] *See*, page 11 (last line) of Partners' Petition.

which would provide anything but fair treatment. Partners seeks favored treatment for the purposes of its own profit. Absolute absolution from "fair treatment" and unfettered freedom from responsibility for any devastation caused by its malfeasance lie at the heart of Partners' Petition for relief. ERISA provides no such relief. Nor, should this Court impute such a goal as being in keeping with its clear intent.

Finally, the entire basis of the District Court's Order remanding this case to the Arizona State Court had to do with its determination that it lacked subject matter jurisdiction over this action. While Partners argues that there are findings of fact and law collateral to the jurisdictional question at the heart of the District Court's Order, there is no support for such an argument. Should this Court grant the relief Partners requests, it will, in essence, be voiding 28 U.S.C. § 1447(d). Such a result would not be beneficial to the orderly administration of justice. Indeed, while Atkins is fully aware that this Court recently liberalized appellate intervention in certain limited instances when remand has been ordered, *Quackenbush v. Allstate Insurance Company*, ___ U.S. ___, 116 S.Ct. 1712 (1996), it did not go so far as to hold that § 1447(d) is nugatory and should be ignored. Nor, should it so have held.

Removal, in and of itself, delays litigation on the merits. *Carte blanche* right to appeal from an order of remand in all circumstances – apart from adding to the already overwhelming and burgeoning caseloads in this Court and the circuit courts of appeal – plays squarely into the hands of those who seek resolution through

delay and obfuscation rather than on the merits.[6] Absent a clear showing that a district court's remand order is based on something wholly collateral to the issue of subject matter jurisdiction, this Court should not open the floodgates by allowing intermediate appeals from all remand orders.

As such, the Writ should be denied.

I.

A FORMER EMPLOYEE WHO HAS NO REASONABLE EXPECTATION OF RETURNING TO COVERED EMPLOYMENT AND WHO HAS NO COLORABLE CLAIM FOR BENEFITS UNDER AN ERISA PLAN HAS NO STANDING TO PURSUE A CLAIM UNDER ERISA AND IS FREE TO PURSUE STATE COURT CLAIMS.

A. Introduction – Public Policy

Public policy dictates that the statutory and decisional law of the bodies who govern our nation be interpreted in accordance with the clear meaning of the language employed by the entity either creating or interpreting the law. Otherwise, like it or not, the law of the land becomes meaningless. Congress clearly set forth who has standing to pursue a claim under ERISA. In *Firestone, supra,* this Court clearly analyzed and interpreted what the legislature enacted. Various circuit courts of appeal have discussed the issue of standing.

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[6] Notwithstanding the vigor of Partners' protestations regarding the purported societal benefits to be reaped by granting the relief sought in its Petition, Atkins has a quite founded reason to believe that delay is a substantial factor giving rise to the filing of Partners' Petition.

Now, Partners would set the language employed by Congress, this Court and the various circuit courts on its ear invoking a claim of "public policy" as a thinly masked disguise for its own naked self-interest. Indeed, notwithstanding Partners' unfounded allegations to the contrary, it is not Atkins who seeks to do violence to the holding in *Firestone*, it is Partners. This Court should not be deceived.

There is no decision of any Court which supports the following statement from Partners' Petition:

> The circuits have created two categories of former employee claimants: (1) those who claim benefits from the period of time while they were covered under the plan; these claimants may sue under ERISA; and (2) those who were never enrolled in the plan or **who have already received all of the benefits to which they were entitled** under the plan; these claimants may not sue under ERISA. [Emphasis added]

While this proclamation may reflect what Partners would have liked the courts to have said, no court has made such a statement. Indeed, if this were the state of the law, one would presume Partners could cite a single decision which would in essence have to hold that if a former employee was denied a benefit at some point, and **even though that benefit is now absolutely worthless and its being conferred would serve no purpose whatsoever,** the former employee has standing to bring a lawsuit in federal court under ERISA. No court has fallen for that particular legerdemain, and, unless ERISA was enacted for the purpose of pretending to create various rights

which in substance do not exist, should any tribunal be so duped.

B. The Statute

While Partners has quoted 29 U.S.C. § 1002(7) in its Petition, it has not provided a word of analysis regarding the words employed in this section by Congress as it relates to a "former employee" who may constitute a "participant" for purposes of standing to pursue a claim under ERISA.

First, it must be pointed out that a determination of participant status is made at the time of filing suit. *Harris v. Provident Life and Acc. Ins. Co.*, 26 F.3d 930, 933 (9th Cir. 1994); *Olson v. General Dynamics Corp.*, 960 F.2d 1418, 1422 (9th Cir. 1991). Partners does not dispute this concept and, indeed, agrees that the time of filing suit initially controls in determining standing[7] as a participant under an ERISA plan. *See*, Partners' Petition, pg. 18, Section I.E.

Thus, according to the clear terms of § 1002(7) in order to be a "participant", a former employee must be – in the context of this case – someone "who **is** or **may become** eligible to receive a benefit of any type from an employee benefit plan [emphasis added . . .]" at the time suit is filed. The words selected by our Congress speak in

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[7] It is undisputed that one who has standing at the beginning of a lawsuit can lose that standing as the action proceeds, *Crawford v. Lamantia*, 34 F.3d 28, 32 (1st Cir. 1994), as Partners has pointed out. What that has to do with the issue before the Court is somewhat perplexing since Atkins has not had standing from the outset in this action.

the present and future tenses. They say nothing with regard to the past.

Were it the Congressional intent, as Partners argues, to include persons such as Atkins as "participants" in an ERISA plan, it would have been a quite simple matter to include any number of simple everyday English words to accomplish that purpose: "was", "has been", "may have been in the past", etc. Those words are not included in the definition.

Congress created ERISA. It created the definitions which apply to the act. It is not the province of this Court (or any other) to second guess what the legislature has clearly enunciated and rewrite the statute. To accept Partners' theory and grant the Petition, this Court would have to find the Congress intended to include past tense language but forgot to do it. It is doubtful there is any case out of any court which considers that proper statutory construction.

C. The *Firestone* Decision

Not only does Partners have the audacity to imply Congress did not mean what it clearly said, it propounds that this Court lacked an understanding of its own words.

> In order to establish that he "may become eligible for benefits," a claimant must have a colorable clain that (1) he will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future . . . A former employee who has neither a reasonable expectation of returning to covered employment nor a colorable clain to vested benefits, however, simply

> does not fit within the [phrase] "may become eligible."

Firestone, supra, 489 U.S. at 117-118. By this writer's understanding, this Court was rather meticulous in underscoring the present and/or future right to claim benefits.[8]

There is certainly no mention in that decision of what can best be described as the "retained standing" which Partners espouses in its Petition. Indeed, the only concern expressed over the Court's decision in *Firestone* is in Justice Scalia's concurring opinion which suggests a concern that the Court's "colorable claim" rationale may be too expansive. Nowhere in *Firestone* is there so much as a hint that one who may have been a "participant" in the past continues *ad infinitum* as a participant for standing or any other purposes under an ERISA plan.

D. The *Harris* Decision

Partners has accused Atkins of providing a misleading interpretation of *Harris v. Provident Life and Acc. Co., supra.* It is Partners' argument that, in *Harris,* lack of a former employee's standing was found "only because he had never been enrolled in the employee benefit plan." Partners' Petition, pp. 19-20. While it is true that the plaintiff in *Harris* had never been enrolled in the plan, there is nothing from the text of that decision which would lead anyone to logically conclude that his lack of

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[8] In *Firestone,* all of the former employees who were found not to have standing at one time had vested benefits under one or more Firestone plan.

standing was **only based** on this factor. Given the Ninth Circuit's rather detailed discussion of who has participant status, it is a strained and contrived interpretation of that decision to argue that plaintiff's **never** having been a participant played any role in the analysis of the court:

> Whether a person is a plan participant must be decided as of the time the filing of the lawsuit. [citations omitted] At the time of filing suit, Lawrence Harris was a former employee of Lincoln. A former employee is a plan participant only if he has "a reasonable expectation of returning to covered employment or [has] a colorable claim to vested benefits. [citation omitted] The Harrises have not established that Lawrence Harris **has** either. [emphasis added]

26 F.3d at 933. The *Harris* court mentions not a single word in this reasoning about Lawrence Harris' **never** having been a participant. Rather, it discusses his status **at the time of filing suit.** If the *Harris* test were as Partners argues, one must ask why did not the *Harris* court simply say so.

Neither *Harris* nor any other decision referenced by Partners stands for the proposition asserted by Partners. Under the pellucid words of the statute defining "participants", and this Court's well-reasoned opinion in *Firestone*, such an interpretation would be clearly erroneous.

E. Atkins' "Colorable" Claim

As Partners tells it, Atkins' colorable claim for benefits is a CT Scan.[9] Partners' Petition, p.21. Were it not so frivolous, this argument might be interesting. Keeping in mind that participant status is determined at the time suit is filed, the following facts are indisputable: (1) the CT Scan was for the purpose of determining what was causing Atkins' intolerable headaches; (2) prior to the rupture of her aneurysm, Atkins neither had nor paid for a CT Scan on her own; (3) once the aneurysm ruptured, any medical necessity for a diagnosis of the cause of Atkins' intractable headaches was fully exposed[10], and a diagnostic CT Scan for purposes of avoiding irreparable harm became irrelevant.

Exposing Partners' illogic in this argument for what it is, this Court should look to its own language in *Firestone, supra* ("[s]he will prevail in a suit for benefits"), and a case referred to by Partners in one of the footnotes (3) to its Petition and which speaks most loudly in Partners' favor. In *Panaras v. Liquid Carbonic Industries Corporation*, 74 F.3d 786, 790 (7th Cir. 1996), the court stated:

> [H]is claim [for purposes of determining standing] must rest on "a colorable claim to vested benefits."

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[9] Atkins will discuss the "benefits v. damages" aspect of this claim more fully later in this Opposition.

[10] Indeed, it is somewhat ironic that Atkins finally received a CT Scan of her head – which Partners paid for – after the aneurysm ruptured and she was taken to the emergency room.

> The requirement of a colorable claim is not a stringent one. This circuit has noted that "Jurisdiction depends on an arguable claim, not on success" and that only if "any claim . . . must be frivolous is jurisdiction lacking."

Assuming *arguendo* that the burden to prove lack of standing rests with Atkins, and, as Partners argues, the colorable claim to benefits is the CT Scan, under *Panaras*, one must ask whether a suit for that benefit brought at the time this suit was filed would have been frivolous. The **only** conclusion in this regard is that such a suit would have been ludicrously frivolous. Once Atkins' aneurysm ruptured, and surgical repair was achieved, there was no need for diagnosis of what was previously creating the pressure inside Atkins' head. Atkins did not pay for the CT Scan in question from her own pocket. Nor, did she have the CT Scan performed despite Partners' denial and incur a liability to a radiologist. Therefore, she had no colorable claim to recover those expenses which Partners' plan was to have provided because she never expended any her own funds or incurred a liability which the plan was to pay for. Once the aneurysm ruptured, the only colorable claim to benefits Atkins possibly could have had related to continued care as provided for under the Partners' plan **if she had continued coverage**. However, she discontinued coverage and, at that point, any claim for benefits under the plan was extinguished.

Partners can point to not a single penny of benefits which may have been due Atkins at the time this suit was filed and for which Atkins could have maintained a colorable claim. Had the CT Scan at one time in the past been a

vested benefit under Partners' plan, at the time this suit was filed a claim for that benefit no longer existed.

F. The "But For" Line of Cases

Candor requires discussion of the extremely limited scenario wherein circuit courts of appeal have granted participant status to a former employee who has neither a foreseeable prospect of re-employment nor a colorable claim for vested benefits. Under the "but for" doctrine participant status was allowed – particularly in light of allegations of wrongful discharge – where:

> [B]ut for the employer's conduct alleged to be in violation of ERISA, the employee *would* [emphasis in original] be a current employee with a reasonable expectation of receiving benefits, and the employer should not be able through its own malfeasance to defeat the employee's standing.

Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1221 (5th Cir. 1992).

The following language found in *Vartanian v. Monsanto Co.*, 14 F.3d 697, 703 (1st Cir. 1994) exemplifies the very limited circumstances under which the "but for" doctrine has applicability in expanding participant status:

> We hold that where an employee alleges a decision to retire based on alleged misrepresentations by his employer amounting to a breach of fiduciary duty, **and** the true facts are not available to the employee until after the employee has received all his vested benefits under a plan; **and further,** where the employee shows that in the absence of the employer's

> breach of fiduciary duty he would have been entitled to greater benefits than those which he received, then his receipt of payment cannot be used to deprive him of "participant" status and hence, standing to sue under ERISA. [emphasis added]

None of the requirements of *Vartanian* can be demonstrated in the instant case. Atkins' termination with her former employer had nothing to do with any representations the former employer or Partners made. Indeed, her choice to end coverage and any rights to benefits under the Partners' plan were completely independent of any action on the part of either Partners or her former employee. To the contrary, the only reason Atkins remained enrolled post-employment with her previous employer in Partners' plan was for the purpose of continuation of coverage while she awaited eligibility under her new employer's health insurer.

To expand the definition of "participant" to include Atkins as Partners argues is appropriate would defeat the spirit and letter of both ERISA and the "but for" cases. Partners sole reason for attempting to convolute the definition of "participant" is to expand without any authority upon the legerdemain which ERISA has become, and avoid responsibility for the damages it has inflicted on Atkins.

G. Benefits vs. Damages

Partners claims that Atkins "has already acknowledged", Partners' Petition, p. 23, her suit seeks benefits. This writer must point out that it is extremely difficult to

acknowledge what one cannot comprehend. Is Partners talking about the pain and suffering benefit under its plan? The emotional distress benefit? Disfigurement? Lost earning capacity? Loss of the enjoyment of life? Atkins can find no provision in her Partners manual which describes these "benefits" and assumes the plan does not provide any such benefit.

All vituperation aside, Partners' reliance on *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan*, 83 F.2d 345 (5th Cir. 1989) is substantially misplaced. While it is true that the distinction between benefits and damages is at times difficult of ascertainment, in the instant situation, there is no difficulty whatsoever. The only benefits Partners can point to under its plan are the payment of health care related expenses **while a participant is enrolled in the plan**. Partners did not provide nor can it argue it provided Atkins with some type of long term or no fault accidental disability coverage. Atkins was only covered for certain necessary health care costs. And, she was only covered **while she paid for continuation coverage under her ERISA plan.**

Interestingly, the *Sommers* court noted that a claim for an "unascertainable amount" is a claim for damages, 883 F.2d at 349. Likewise, Atkins' claim is one which could never be made certain by computation. It is clearly a claim for damages.

This Court should see the wolf through sheep's clothing which lies at the heart of Partners' "benefits vs. damages" claim. What Partners is really arguing, but cannot overtly, is that Atkins' claim for damages arises

out of a denial of benefits under an ERISA plan. Purportedly, it, therefore, relates to an ERISA plan, and preemption must apply. However, Partners is foreclosed from making such an argument by *Arizona Carpenters Pension Trust Fund v. Citibank*, 96 F.3d 1317 (9th Cir. 1996).[11] In *Arizona Carpenters*, the Ninth Circuit recognized that a state law[12] "relates to" an employee benefit plan, "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed. 2d 490 (1983). Preemption under ERISA "extends to all claims which, directly or indirectly, arise from administration of the plan. *Concha, supra*, 62 F.3d at 1504-05."

> On the other hand, "[n]otwithstanding the remarkable legerdemain that has turned a statute designed to protect employees' pension rights into a law that strips them of most of the protection they previously enjoyed under state law, there are limits to the unusually broad preemptive sweep we have afforded ERISA." [citations omitted] . . . For example, ERISA does not preempt state law claims if plaintiffs have no standing to challenge the ERISA violations. [citation omitted] Similarly, "[i]f the plaintiff is not a participant, beneficiary, or fiduciary, then his state law claims fall outside ERISA's sphere and are not subject to preemption."

96 F.3d at 1317.

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[11] This case is glaring in its absence from inclusion in the 22 precedents cited in Partners' footnotes 3 & 4 (pp. 15-16 of Partners' Petition), which purportedly contain all important circuit court decisions on the issue of standing under ERISA.

[12] Such as a common law claim for negligence or breach of contract.

Atkins' claim arises out of a "benefit [which was] denied". It is not a claim for benefits. Unless she had a colorable claim for benefits at the time this action was filed, she did not have standing to pursue an ERISA action whether her claim related to the plan or not. She had no such colorable claim. Her action sounds solely in damages not for the purpose of evading ERISA. Rather, the only claim Atkins has is for damages. She has no, nor had at the time of filing, standing to bring a claim under ERISA.

The lower courts have done no violence to *Firestone*. Their decisions must stand.

II.

UNDER THE CLEAR LANGUAGE OF 28 U.S.C. § 1447(d), APPELLATE REVIEW OF A DISTRICT COURT'S ORDER OF REMAND IS INAPPROPRIATE WHERE THE SOLE BASIS FOR SUCH ORDER OF REMAND IS LACK OF SUBJECT MATTER JURISDICTION.

Partners' reference to *Quackenbush v. Allstate Insurance Co.*, ___ U.S. ___, 116 S.Ct. 1712 (1996), and the fact that it "overruled" *Thermtron Products, Inc. v. Hermansdorfer*, 423 U.S. 336 (1976) is somewhat misleading in light of the argument Partners goes on to make. The Court's disapproval of *Thermtron* is limited to the procedural vehicle for review of an order of remand, i.e., writ of mandamus vs. direct appeal from an interlocutory order. In *Quackenbush*, this Court allowed for direct appeal, because the lower court's order of remand was

"functionally indistinguishable from the stay order we found appealable in *Moses H. Cone.*"[13]

Nowhere in *Quackenbush* did this Court so much as hint that 28 U.S.C. § 1447(d) no longer lacked vitality or is invalid and that orders of remand based on a lack of subject matter jurisdiction may be reviewed.

In this case, the District Court's order was solely based on its lack of subject matter jurisdiction notwithstanding Partners' claims to the contrary. Nothing in the District Court's order and the Ninth Circuit's refusal to review it does violence to the holding in *Executive Software v. U.S. District Court*, 24 F.3d 1545, 1549 (9th Cir. 1994):

> [I]n this circuit, to qualify as "collateral" the order must resolve[ ] the merits of a matter of *substantive law* [emphasis in original] apart from any jurisdictional decision.

Clearly, in order to determine whether a statutory scheme such as ERISA confers subject matter jurisdiction on the court, any district judge must analyze the statute. It would be impossible to determine the existence or non-existence of subject matter jurisdiction without such analysis. The issue to be determined is whether the district court's analysis of a substantive question of law goes beyond the "ambit of section 1447(c)". *Clorox Company v. United States District Court*, 779 F.2d 517, 520 (9th Cir. 1985). If it does, the order is reviewable; if it does not, jurisdiction for review does not exist.

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[13] *Moses H. Cone Memorial Hospital v. Mercury Constr. Corp.*, 460 U.S. 1, 103 S.Ct. 927, 74 L.Ed. 2d 765 (1973).

Eminently on point given the issues in the instant action is *Survival Systems v. United States District Court*, 825 F.2d 1416, 1418 (9th Cir 1987), wherein the Court held:

> "The ruling of the district court was that the state causes of action alleged in Rodriguez's complaint was not an artfully pled federal claim that was preempted by federal labor law. This did not finally resolve the issue of preemption, which could still be raised as a defense to the state claim in the state court. Thus, if the proof in state court were such as to justify the conclusion that the cause of action was completely preempted by federal labor law, the defense of preemption could be sustained. The ruling of the district court was simply that the allegations of the complaint did not justify such a result.
>
> . . .
>
> Therefore, the remand is not reviewable on appeal as a substantive decision under the doctrine of *Pelleport*[14] and *Clorox* [*supra*].

Neither has the issue of preemption – or any other substantive issue – been foreclosed by the District Court's remand order in the instant case. Based on the facts available to the District Court, Atkins did not fall within the definition of a "participant", and therefore her claim was not preempted. Based on her pleadings, a federal question did not exist and remand on the basis of lack of subject matter jurisdiction was not only appropriate but mandatory. As such, no appellate review is allowable

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[14] *Pelleport Investors, Inc. v. Budco Quality Theaters, Inc.*, 741 F.2d 273 (9th Cir. 1984).

under 28 U.S.C. § 1447(d). Should Partners develop sufficient facts in the Arizona State Courts, the defense of preemption is available to it. *See, New Orleans Public Service v. Majoue*, 802 F.2d 166, 168 (5th Cir. 1986) (Holding district court's remand order is only *res judicata* as to the forum. "The issue [of ERISA preemption] should now be determined together with the merits, in the first instance, by the [state] courts.")

Partners has accurately listed the five considerations to be weighed in determining the propriety of a writ of mandamus. However, Partners has blatantly misconstrued and misrepresented the import of the Ninth Circuit's decision in *Survival Systems, supra.* In *Survival Systems*, the court did find the third factor (whether the district court's order constitutes clear error as a matter of law) dispositive. However, that factor was found to be dispositive because the district court **did not** err and, therefore, it would have been inappropriate to grant relief via mandamus. The converse as propounded by Partners is riddled with logical fallacy, and is simply not a fair statement of the law. Were the third factor dispositive in all cases – as it would have to be according to Partners' argument – why the need for having four other factors? Clearly, the additional four factors are not included in order that circuit court judges will perform weighing tests regarding them, only to have whatever weight may be accorded of no materiality because factor three is always dispositive.

However, in this case, notwithstanding Partners' attempted misuse of *Survival Systems*, the third factor is, indeed, dispositive because "[w]hen the district court's order is correct as a matter of law . . . the writ of

mandamus should not issue." 825 F.2d at 1418. Here the District Court's order is correct as a matter of law for reasons set forth in detail, *supra*.

Even were there a need for the Court to consider the other four factors, Partners has provided no persuasive argument as to why it should prevail. (1) Partners retains all appellate remedies afforded by Arizona law; (2) there is no indication that the Arizona judiciary cannot or will not apply the appropriate law, and therefore there can be no showing of prejudice or damage; (3) Partners has pointed to no other case which has arisen since the enactment of ERISA on all fours with this one, and therefore its "oft-repeated error/persistent disregard" argument is founded upon nothing; and (4) the district court's order is in keeping with numerous other orders out of the various circuits and this Court on the issue of who constitutes a "participant" for standing purposes and is consistent with all such pronouncements.

The Ninth Circuit panel which dismissed Partners' appeal and denied its petition for a writ of mandamus did absolutely nothing at variance with its decision in *Executive Software v. United States District Court*, 24 F.3d 1545 (9th Cir. 1994), as Partners argues.[15]

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[15] In *Executive*, the Ninth Circuit noted that the district court remanded part of the action but "retained jurisdiction over the federal claims." The court noted that it had previously held that retention of jurisdiction over at least one of the claims "removes the possibility that a remand order is issued pursuant to section 1447(c), *Kunzi v. Pan American World Airways, Inc.*, 833 F.2d 1291, 1295 (9th Cir. 1987)," and as such section 1447(d) does not act as a bar to review. 24 F.3d at 1549. Here, the District Court remanded Atkins' entire claim. That portion of the

Pursuant to 28 U.S.C. 1447(d), the Ninth Circuit lacked jurisdiction to review this case by appeal or otherwise. For the same reasons, this Court must deny Partners' Petition for a Writ of Certiorari.

CONCLUSION

At the time Atkins brought suit against Partners seeking damages, she did not, under any theory, meet the definition of a "participant" under ERISA as defined by 29 U.S.C. § 1002(7). As such she lacked standing to bring an action in federal court, and, because Atkins' claims are not preempted, she is free to pursue her state court claims. The District Court lacked subject matter jurisdiction over this case and properly remanded it to state court on that basis.

Neither the Ninth Circuit had nor this Court has jurisdiction to review the District Court's order under the clear terms of 28 U.S.C. § 1447(d). Neither would a writ of mandamus have been appropriately issued by the Ninth Circuit, nor would a writ of certiorari appropriately issue from this Court.

Executive analysis relied upon by Partners, as such, does not even apply to this case. The entire balance of that case speaks against Partners' argument.

Therefore, Partners' Petition for a Writ of Certiorari must be denied and any relief sought thereunder denied.

Respectfully submitted,

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